will point to a lesion at this part of the tract. With the exception of neuritis, we have general symptoms in all these conditions to aid us in a diagnosis. A *neuritis of the eighth nerve* might cause confusion, particularly if there should happen to be an otitis media existing at the same time. The following points will be of service in reaching a conclusion as to the cause. We will not consider a neuritis affecting only the cochlear division as it would hardly be mistaken for labyrinth suppuration.

	Labyrinth Suppuration. (Destructive Stage).	Neuritis of the 8th Nerve.
History	One of middle ear suppuration.	No history of ear suppuration the rule. History of an infectious disease, or poisoning by tobacco, alcohol, quinin, salicylates, lead, or exposure to damp cold.
Tinnitus	Negative.	Positive if cochlear branch is involved, which is usually the case.
Deafness	Absolute.	Usually partial—absolute if the entire nerve is involved.
Herpes	None.	May be found on drum, auricle or in the canal.
Vertigo	Intense at first but improving after a week.	Intense and lasting longer than in labyrinth suppuration.
Equilibrium disturbances	Present.	Present.
Spontaneous nystagmus	To well side.	To well side.
Caloric reaction	Negative.	Negative.
Galvanic Irritability	Present.	Absent.
	No other cranial nerves involved excepting the seventh rarely.	Coincident neuritis of other cranial nerves very likely.
	One ear affected.	Often bilateral.
	Permanent loss of function.	Recovery probable.

Of the diseases of the end organ itself we must consider peri-labyrinthitis, erosions or fistulae of the labyrinth wall, circumscribed irritative lesions, diffuse irritative lesions, circumscribed destructive lesions and diffuse destructive lesions of the membraneous labyrinth.

Peri-labyrinthitis is an inflammation extending into the peri-labyrinthine bone cells surrounding the labyrinth capsule, from the middle ear suppuration. It occurs in cases of low resistance such as are found in diabetes and in tubercular ears. It leads to partial or complete sequestration of the bony labyrinth. The secondary dangers of intra cranial complications are not so great as in labyrinth suppuration with the exception of eventual tubercular meningitis in the tubercular cases. The signs are much like those of labyrinth irritation, but the following points may be of service in distinguishing them:

Labyrinth Suppuration.	Peri-Labyrinthitis.
More often secondary to chronic otitis media.	More often secondary to acute otitis.
Onset of labyrinth symptoms sudden.	Onset gradual.
Facial palsy exceptional, and when present has no direct connection with labyrinth suppuration.	Facial palsy nearly always present as seventh nerve passes through the peri-labyrinthine cells.
Necrotic bone not always present.	Necrotic bone in all advanced cases.
No constitutional disease.	Associated with diabetes and tuberculosis.
Weber goes to well ear.	Weber often lateralized in affected ear.

(To be concluded in December.)

PROCEEDINGS OF THE SAN FRANCISCO COUNTY MEDICAL SOCIETY.

During the month of September the following meetings were held:

Medical Section, Tuesday Evening, Sept. 5th.

1—Case Demonstrations.

(a) Polycystic Kidneys.

(b) Dislocation of Atlas on Axis due to Lues. René Bine.

2—Newer Aspects of Protein Metabolism. Prof. R. E. Swain. Discussed by Drs. Schmoll, Power and Swain.

3—The Life of Radium and Its Therapeutics, with demonstrations. E. O. Jellinek.

Regular Meeting, Tuesday Evening, Sept. 12th.

1—Clinical use of Psychotherapy; Illustrated by Cases from Private Practice. Carl Renz, M. D.

2—Therapeutic Value of Psychotherapy. Geo. H. Richardson.

General discussion by Drs. Power, Rosenstirn, Welty, McClenahan, Horn, Pfeiffer, Vecki, Watkins, Bine, Renz.

Surgical Section, Tuesday Evening, Sept. 19th.

1—Case of Anthrax Pustules. J. C. Newton.

2—(a) Resection of Shoulder Joint for Tuberculosis.

(b) Left Sided Colon.

(c) Carcinoma of the Pylorus.

(d) Excision of Vocal Cord for Epithelioma.

(e) Compound Pott's Fracture and Dorsal Dislocation of Great Toe. Emmet Rixford.

3—Operative Treatment of Fractures. T. W. Huntington. Discussed by Drs. Rixford and Huntington.

4—Case demonstration. Stanley Stillman. Discussed by Drs. Hyman and Stillman.

5—(a) Exophthalmic Goiter.

(b) Ovarian Cyst with Twisted Pedicle and Fibroid of Uterus.

(c) Lymphadenitis.

6—Epithelioma of Ear. S. J. Gardner.

7—Fractured Clavicle. Sterling Bunnell.

8—Demonstration of Screw for Treatment of Fractures. James T. Watkins.

Eye, Ear, Nose and Throat Section, Tuesday, Sept. 26, 1911.

1—Demonstration of a Case of Synchisis Scintillans. Victor F. Lucchetti.

2—(a) Report of a Case of Lockjaw Caused by Spasm of the Internal Pterygoid.

(b) Report of a Case of Acute Mercury Poisoning with Necrosis of Superior Maxillary and an Acute Otitis Media. Adolph Baer.

3—Tuberculosis of the Uveal Tract. Edgar W. Alexander.

4—On the Paralysis of the Abducens of Otitic Origin. Victor F. Lucchetti.

Section on Medicine, Sept. 5th, 1911.

Case Demonstrations by René Bine.

(a) Polycystic Kidneys.

(b) Dislocation of Atlas on Axis Due to Lues.

(This case report is published in full elsewhere in this issue.

Polycystic Kidneys.

I am greatly indebted to my good friend, Dr. Isnardi, who has not only given me the privilege of examining this patient with him, but who has consented to my demonstrating him to this audience.

Polycystic kidneys in the adult are not common. Their pathogenesis is quite obscure. Every writer on diseases of the kidneys devotes pages to its discussion, whether he has ever seen or studied a case or not. The condition may go on for years without giving rise to symptoms. In the terminal, uremic stage, the diagnosis is simple. In intermittent stages the diagnosis is almost obvious, if many cases resemble this one, as is claimed by most writers.

Mr. C. F., age 38, contractor, complained of colicky pain in the abdomen, present to some degree for perhaps twenty years, but much worse for the last two years. Bowels costive. The only other points elicited in the history, after careful questioning, were that there were frequent nose bleeds for years, but for six months none had occurred. In particular, the patient had none other of those symptoms described by Dieulafoy as "petits signes du brightisme."

Examination of the patient showed practically normal chest; blood pressure was normal. Blood, 72%; Hg., 3,500,000 R. B. C.; 10,000 W. B. C.; 62 polys; 3 L. M.; 35 S. L.; O. E. Some poikylocytosis. No plasmodia. Wassermann negative.

The urine examined but once after prolonged palpation, contained a marked trace of albumin. Microscopic examination of the sediment showed many red blood cells.

The abdomen is most interesting and those desirous of examining the patient will note that there are large, firm, reniform masses in the flanks, that can be grasped bimanually as well as ballotted, and their position and mobility leave no doubt that they are enlarged kidneys. Furthermore careful palpation reveals numerous nodules on their surface, which seem less firm than other parts of the mass.

Of further interest will be noted the large liver descending fully one inch in the midclavicular line, but here no nodules are felt. And most interesting of all, very careful examination will note that the splenic edge is just palpable below the costal margin. It is hard to separate from the upper pole of the large left kidney, and for that reason I at first missed it.

Whether the patient has a Banti's disease as a complication is a point to be decided at a later date, as I am seeing the patient to-night only for the third time.

Clinical Use of Psychotherapy Illustrated by Cases From Private Practice.*

By CARL RENZ, M. D., San Francisco.

The purpose of this paper is to discuss briefly the nature of psychotherapy, to illustrate its use from personal clinical experience and to give a hint of its value in the work of the general practitioner. I shall, therefore, not give any historical data nor dwell to any great extent upon its psychological aspect, although the latter is a sine qua non for the understanding of the phenomena.

Suggestion is of course the integral part of all methods of psychotherapy. Most physicians use suggestion in the treatment of their patients; some do it deliberately, others unconsciously. Hypnotism constitutes but one method of psychotherapy. The increased suggestibility to hetero-suggestion is the fundamental characteristic of the state of hypnosis. As to whether suggestions should be given in the hypnotic or in the wake state, I prefer the hypnotic state as giving better results; and I fully agree with Dr. Bonjour of Lausanne, who said in a recent article in the Revue Suisse de Medecine: "Je ne doute pas que ceux qui rechercheront l'hypnose profonde obtiendront des resultats plus excellents et plus durables que ceux qui se contentent d'hypnoses légères ou simplement de la suggestion directe ou indirecte."

With regard to the technique for inducing a hypnotic state, most psychotherapists in course of time work out one of their own, or, at any rate, modify or combine known procedures. In fact, one can hardly adhere to one technique with all patients, or to one technique with the same patient all the time. Personally, I use verbal suggestion without any special apparatus. However, I have seen Bérillon use a tuning fork, and in difficult cases he injects three or four deci milligrams of scopolamin, which he calls "Un veritable medicament psychologique." Farez uses blue light and v. Schrenk-Notzing and others use chloral hydrate in cases which prove refractory to simple verbal suggestion.

About thirty years ago Charcot, at the Salpétrière, pronounced hypnotism to be a typical hysterical symptom, and he based his opinion upon the fact that all symptoms of hysteria can be elicited in hypnosis. But because we observe hypnotic states in pathological conditions, it does not follow that hypnosis is to be classed with the pathological states when the suggestibility is not abnormal. The Nancy school is opposed to Charcot's view, and the majority of investigators to-day share Bernheim's opinion. Hypnosis is a physiological condition of the nervous system and not a pathological one.

Hypnosis can be induced in almost all normal persons. Of course, the degree of susceptibility varies very much. Gerrish says: "The hardest-headed of us can be reached by a sufficiently frequent and skillful repetition of a suggestion." Many of the most susceptible persons are a priori convinced that they are immune to the influence of suggestion. It is commonly believed that it is easier to hypnotize a person of a low degree of intelligence or weak will power than one of a high degree of intelligence or strong will power. This is an error, for no such relation exists. The truth is that the co-operation of the subject is necessary. He must possess a certain ability to concentrate his attention. If the subject resists hypnosis, particularly during the first attempts, it will be very difficult, if not impossible, to influence that person. Lack of power of concentration is one of the most frequent causes of refractiveness to suggestion. Young children are

* Read before the San Francisco County Medical Society, September 12, 1911.